

## DEPARTMENT OF HUMAN SERVICES INDIVIDUAL PLAN OF CARE

NAME: \_\_\_\_\_ CASE# \_\_\_\_\_ DATE: \_\_\_\_\_  
 WAIVER START DATE: \_\_\_\_\_  
 SCW: \_\_\_\_\_ RL: \_\_\_\_\_ TEL: \_\_\_\_\_ FAX: \_\_\_\_\_

☐ INITIAL ASSESSMENT

☐ REASSESSMENT

☐ CHANGE

☐ CORE

☐ PREVENTIVE

☐ DEA

1.	Service:	<b>PERSONAL CARE</b>
	Provider:	
	Provider:	
	Frequency:	
2.	Service:	<b>HOMEMAKING SHOPPING, MEALS</b>
	Provider:	
	Provider:	
	Frequency:	
3.	Service:	<b>MEALS ON WHEELS</b>
	Provider:	
	Frequency:	
4.	Service:	<b>ERS</b>
	Provider:	
5.	Provider:	<b>MINOR ASSISTIVE DEVICES</b>
	Device:	

6.	Service:	<b>ADULT DAY CARE</b>
	Provider:	
	Frequency:	
7.	Service:	<b>CASE MANAGEMENT</b>
	Provider:	
	Frequency:	
8.	Service:	<b>RESPIRE SERVICE</b>
	Provider:	
	Frequency:	
9.	Service:	<b>SENIOR COMPANION</b>
	Provider:	
	Frequency:	
10.	Service:	<b>OTHER*</b>
	Provider:	
	Frequency:	

TOTAL HHA HOURS: \_\_\_\_\_ /MONTH      CLIENT'S MONTHLY SHARE \$: \_\_\_\_\_

\* Other CORE services: Comm. Transition Services, Shared Living, Assisted Living (L or F), Private Duty Nursing, Respite, PT/OT.

Waiver Service		Base Rate	Hours Per Week	Month/Total
1	PERSONAL CARE	\$ 17.24/HR	(X 4.333)	
2	HOMEMAKING, SHOPPING, MEALS	\$ 16.16/HR	(X 4.333)	
COMBINED		\$ 16.64/HR	(X 4.333)	
3	MEALS ON WHEELS	\$ 4.50/MEAL	Meals per month	
4	ERS	\$ 35.00/MONTH		
5	MINOR ASSISTIVE DEVICES	\$		
6	ADULT DAY CARE	\$	***Included in State Plan***	-0-
7	CASE MANAGEMENT	\$ 60.00/HR		
8	RESPIRE SERVICES	\$		
9	SENIOR COMPANION	\$ 8.50/HR	(X 4.333)	
10	OTHER*	\$		
<b>TOTAL:</b>				

Participant/Representative Signature

SCW/Supervisor Signature